PATIENT INFORMATION

Patient Name_____DOB:_____**Email**:_____

Address_____

Cell:_____Home:_____ Work:_____

Emergency contact name and phone number:_____/_____

Primary care physician Name:_____ Phone:_____Fax:_____

Pharmacy Name/Address/Phone number:_____

**List of current medication/strength/frequency:

**Do you have chest pain? Yes / No **Do you have Shortness of breath? Yes / No

Are you diagnosed with any of the following?

____Diabetes _____ High Cholesterol ____ Atrial Fibrillation _____Cancer
____ High Blood Pressure _____ Sleep Apnea ____ CAD (Coronary Artery Disease)
____PVD (Peripheral Vascular Disease _____ Renal Failure ____ DVT (Deep Vein Thrombosis)

If anyone in your family diagnosed with any of the following? (If YES, please give RELATION of your family member)

****Father (alive/deceased) Mother (alive/deceased)**

___Heart Attack (mother/ father/siblings) _____ Heart Disease (mother/ father/siblings)
___Stroke (mother/ father/siblings) _____Diabetes(mother/ father/siblings)
___High Blood Pressure (mother/ father/siblings) _____High Cholesterol (mother/ father/siblings)
___Congestive Heart Failure (mother/ father/siblings)

Are you **allergic to any medications? Yes / No (If yes, Please list them below and explain the type of reaction)

_____

****Social History:**

Are you a former smoker? Yes / No Are you a current smoker? Yes/No If yes, how many packs per day? _____

Do you drink alcohol? Yes / No If yes, how often?_____

Do you take recreational/street drugs? Yes/ No

Authorization to leave message at Home and/or Cell phone: Yes No

INSURANCE INFORMATION

Primary Insurance:_____ HMO PPO POS SELF
Id#_____Group#_____
Primary Insured Person:_____ __
DOB:_____/_____/_____ SSN#_____-_____-_____
Relationship to Primary Insured Person: Self Spouse Dependent

Office Policies: Kindly note that **checks are not accepted** at our business. We accept cash and all major credit cards.
I, hereby request that payment of authorized Medicare and other insurance carrier benefits be made on my behalf to Pearland Cardiovascular Associates for any services furnished to me by the personnel of this group. I have been given the chance to review the privacy policies of the medical office and agree with its terms. **I agree the provider may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. All past due balance and copay/coinsurance due at the time of visit.**
I agree to pay the balance due for any covered and/or non-covered services provided to the patient.

Signature of guarantor **Date**